STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 121163-001**

Humana Insurance Company
Respondent

Issued and entered
this 12th day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 3 2011, XXXXX (Petitioner) filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner notified Humana Insurance Company (Humana) of the external review and asked for the information it used to make its final adverse determination. Humana furnished the information on May 4, 2011. On May 10, 2011, after a preliminary review of the information received, the Commissioner accepted the request for external review.

The Petitioner has health care coverage under a Humana individual insurance plan. His benefits are defined in a certificate of insurance (the certificate) issued by Humana. The issue here can be resolved by an analysis of the terms of the Petitioner's health care coverage and applicable law. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner's coverage with Humana was effective on December 20, 2010. On December 13, 2010, during a routine visit with his primary care physician, he reported experiencing right upper quadrant abdominal pain. Because of the pain, his physician

recommended he undergo a HIDA[1] scan, a nuclear imaging procedure used to evaluate the health and function of the gallbladder. The scan was performed on December 29, 2010, and the provider's charge was $600.00.

Humana denied coverage for the scan on the basis that it was for the treatment of a pre-existing condition and therefore excluded from coverage during the first 12 months from his effective date.

The Petitioner appealed the denial through Humana's internal grievance process. At its conclusion, Humana upheld its denial and issued a final adverse determination dated March 25, 2011.

III. ISSUE

Did Humana correctly deny coverage for the Petitioner's December 29, 2010, HIDA scan as treatment for a pre-existing condition?

IV. ANALYSIS - A

In its final adverse determination, Humana explained its reason for denying coverage for the HIDA scan:

> We were unable to approve the services provided to you on December 29, 2010 . . . because we found that your pre-existing condition of abdominal pain and splenomegaly was the reason for the service provided. Your policy was effective on December 20, 2010; therefore, the pre-existing condition timeframe will expire on December 19, 2011.
>
> Your medical records do indicate you produced signs or symptoms within six months prior to your effective date of the policy and would have caused an ordinarily prudent person to seek treatment. The medical records indicate that you have received treatment for abdominal pain on December 13, 2010 and splenomegaly on December 14, 2010 and did not disclose this condition on your application of insurance with Humana. While we empathize with your situation, we must follow the provisions of your policy.
>
> Your letter indicates that on December 20, 2010 you called the HumanaOne customer service department and our representative told you should not have a problem with pre-existing conditions on your policy. After review of the documentation from this phone call there is no indication that pre-existing was discussed. Please understand that the benefits provided telephonically are in response to questions posed, which may or may not apply to the actual situation.

1 Hepatobiliary iminodiacetic acid.

Humana based its determination on language in the certificate which excludes coverage for the first 12 months after the effective date of coverage for any treatment of a pre-existing condition. The pre-existing condition limitation on p. 32 of the certificate states: [2]

> **a. What is a pre-existing condition?**
>
> A *sickness* or *bodily injury* and related complications for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a *healthcare practitioner* or *prescription* drugs were prescribed during the six month period immediately prior to the *covered person's effective date*, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed.
>
> **b. Pre-existing condition limit**
>
> *We* will not pay benefits for *services* rendered for *pre-existing conditions* or complications of a *pre-existing condition* for a period of 12 months from the *effective date* of the *covered person* unless those conditions were fully disclosed on the enrollment form for this *Certificate* and benefits relating to those conditions are not specifically excluded.
>
> Any condition not disclosed on the enrollment form may result in rescission or reformation of this *Certificate* and/or modification of benefits. Rescission means that coverage is void from the *effective date*. See the "Incontestability" provision in the "General Provisions" section.

In the "General Exclusions" section of the certificate (p. 33), coverage for pre-existing conditions is excluded:

> Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:
>
> * * *
>
> 8. *Pre-existing conditions* to the extent specified in the *Certificate* . . .

The Petitioner consulted with a healthcare practitioner for his gallbladder complaint (pain) on December 13, 2010, a date within the six months immediately prior to the effective date of his coverage. He then had the HIDA scan on December 29, 2010, which was within the

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2 The language in the certificate substantially comports with Section 3406f(1)(a) of the Michigan Insurance Code:

> (1) An insurer may exclude or limit coverage for a condition as follows:
>
> (a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate. MCL 500.3406f(1)(a).

first twelve months of his coverage. There is no dispute that the HIDA scan was related to a condition "for which medical advice, consultation, diagnosis, care or treatment was sought, received or recommended from a healthcare practitioner . . . during the six month period immediately prior to the covered person's effective date. . . ." The Commissioner concludes and finds that the HIDA scan was for the treatment of a pre-existing condition and therefore not a covered benefits under the terms of the certificate.

Analysis - B

In his request for external review, the Petitioner also raised these arguments:

> I was denied benefits for medical services date 12/29/10. . . . Reason was that condition was a pre-existing condition. I could not disclose this condition on my application for ins. from Humana since my application was submitted to Humana in Nov. 2010 & my condition happened in 12/2010. Also see cert[ificate] of creditable coverage from United Healthcare which I believe should reduce exclusion period for coverage of pre-existing conditions.

Humana, in its final adverse determination, made it sound as though its denial was based at least in part on the Petitioner's failure to disclose his gallbladder condition on his application for insurance. But as the Petitioner points out, he had not been seen for the gallbladder pain at the time he electronically submitted his application to Humana in November 2010. However, Humana's denial was not based solely on the fact that the gallbladder condition was not disclosed on the application for insurance; there were medical records that Humana reviewed that established the pre-existing condition without regard to the Petitioner's application.

The Petitioner also indicates that the exclusion period for pre-existing conditions should be reduced because of his prior group coverage - - he understood that his 18 months of prior continuous coverage would reduce or eliminate the exclusionary period for pre-existing conditions.

The Petitioner had group coverage from February 1, 2006 through December 19, 2010. He received a "certificate of creditable coverage" from XXXXX attesting that he had at least 18 months of continuous coverage. The certificate of creditable coverage documented that the Petitioner might need it "to reduce the exclusion period before your new health benefit plan covers a pre-existing medical condition." On November 9, 2010, the Petitioner electronically submitted an application to Humana for individual coverage. The coverage with Humana was effective on December 20, 2010, but came with a pre-existing condition limitation.

Regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) give eligible individuals the right to purchase some form of individual health insurance without a pre-existing condition limitation if they meet certain criteria. "Eligible individual" is defined in 45 CFR § 148.103:

> *Eligible individual* means an individual who meets the following conditions:
>
> (1) The individual has at least 18 months of creditable coverage (as determined under §146.113 of this subchapter) as of the date on which the individual seeks coverage under this part.
>
> (2) The individual's most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any of these plans).
>
> (3) The individual is not eligible for coverage under any of the following:
>
> (i) A group health plan.
>
> (ii) Part A or Part B of Title XVIII (Medicare) of the Social Security Act.
>
> (iii) A State plan under Title XIX (Medicaid) of the Social Security Act (or any successor program).
>
> (4) The individual does not have other health insurance coverage.
>
> (5) The individual's most recent coverage was not terminated because of nonpayment of premiums or fraud. . . .
>
> (6) If the individual has been offered the option of continuing coverage under a COBRA continuation provision or a similar State program, the individual has both elected and exhausted the continuation coverage.

Under 45 CFR § 148.120, eligible individuals may request coverage in the individual market without a pre-existing condition limitation - - but there is an exception:

> (a) General rule. Except as provided for in paragraph (c) of this section, an issuer that furnishes health insurance coverage in the individual market must meet the following requirements with respect to any eligible individual who requests coverage:
>
> (1) May not decline to offer coverage or deny enrollment under any policy forms that it actively markets in the individual market, except as permitted in paragraph (c) of this section concerning alternative coverage when no State mechanism exists. An issuer is deemed to meet this requirement if, upon the request of an eligible individual, it acts promptly to do the following:
>
> (i) Provide information about all available coverage options.
>
> (ii) Enroll the individual in any coverage option the individual selects.

> (2) May not impose any pre-existing condition exclusion on the individual.
>
> (b) Exception. The requirements of paragraph (a) of this section do not apply to health insurance coverage offered in the individual market in a State that chooses to implement an acceptable alternative mechanism described in §148.128. . . .

Thus, under the HIPAA regulations, the pre-existing condition limitation is prohibited if the eligible individual does not have access to an "acceptable alternative mechanism." However, Michigan has an acceptable alternative mechanism: Blue Cross Blue Shield of Michigan (BCBSM) is required by law to provide individual coverage[3] and to do so without a pre-existing condition limitation when these conditions are met:

> (a) The person's most recent health coverage prior to applying for coverage with the health care corporation was under a group health plan.
>
> (b) The person was continuously covered prior to the application for coverage with the health care corporation under 1 or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.
>
> (c) The person is no longer eligible for group coverage and is not eligible for Medicare or Medicaid.
>
> (d) The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud a health care corporation, a health insurer, or a health maintenance organization.
>
> (e) If the person was eligible for continuation of health coverage from that group health plan pursuant to the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82, he or she has elected and exhausted that coverage. MCL 550.1402b(3).

Because BCBSM provides individual coverage as an "acceptable alternative mechanism," other insurance plans, like Humana, are not required to provide individual health care benefits without a pre-existing condition limitation.[4]

Finally, the Petitioner stated that he contacted Humana by telephone before he had the HIDA scan to see if it would be covered and was told by a Humana representative that it would be and that the pre-existing limitation would not apply. Humana disputes that contention and indicates that it reviewed the documentation of the telephone call and "there is no indication that pre-existing was discussed." Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms of the applicable insurance contract and state law.

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3 See MCL 550.1401(3)(a).

4 The record is not clear whether or not the Petitioner met the five conditions for necessary to qualify for individual coverage from BCBSM without a pre-existing condition limitation.

Resolution of a factual dispute like the one described here cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedure necessary to make findings of fact based on evidence such as oral statements.

Based on the record in this case, the Commissioner concludes that Humana correctly applied the pre-existing condition limitation.[5]

V. ORDER

The Commissioner upholds Humana Insurance Company's adverse determination of March 25, 2011. Humana is not required to waive the pre-existing limitation and cover the Petitioner's HIDA scan performed on December 29, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner

5 It is possible the Petitioner might have avoided the pre-existing limitation by electing coverage under an individual conversion policy upon termination of his prior group coverage. See MCL 500.3612. However, there is nothing in the record to show that he was offered conversion coverage.